# City of Norfolk

## REQUEST FOR REIMBURSEMENT

Instructions: Please complete all applicable spaces on this form for each reimbursement requested, attach itemized receipt/bill and forward to Department of Human Resources via interoffice mail or by U.S. mail to Department of Human Resources, 100 City Hall Building, East Wing, Norfolk, VA 23501. Please print clearly. All reimbursement claims will be paid through the City's normal payroll system. Claims must be in the Department of Human Resources by the appropriate due date.

Name _____
(Last) (First) (Middle Initial)

Social Security Number _____ Business Phone _____

Department/Bureau _____

Home Address _____
(PROVIDE ONLY IF CHANGED) (NUMBER, STREET) (CITY, STATE) (ZIP)

CHECK HERE IF NEW ADDRESS ☐

**Reimbursement For:**

Provider(s) of Service _____
(NAME OF DOCTOR, DENTIST, PHARMACIST, ETC. FOR SELF AND FAMILY)

SSN/Tax I.D. Number of Dependent Care Provider _____
(DEPENDENT CARE REIMBURSEMENT ACCOUNT ONLY)

Person(s) Receiving Service _____
(SELF, SPOUSE, CHILDREN AND ELIGIBLE DEPENDENTS)

Relationship _____

Date(s) Service Provided ___/___/___ through ___/___/___

Total Amount of Reimbursement Requested $_____. _____ TOTAL DOLLAR AMOUNT ONLY

ALL ATTACHED RECIEPTS ARE: (CHECK ONLY ONE)

☐ CHILD CARE
☐ HEALTH CARE

I CERTIFIY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, MY STATEMENTS IN THIS REQUEST FOR REIMBURSEMENT ARE COMPLETE AND TRUE. I AM CLAIMING REIMBURSTMENT ONLY FOR ELIGIBLE EXPENSES INCURRED DURING THE APPLICABLE PLAN YEAR AND FOR ELIGIBLE PLAN PARTICIPANTS. I CERTIFY THAT THESES EXPENSES HAVE NOT BEEN/WILL NOT BE REIMBURSED UNDER THIS OR ANY OTHER BENEFIT PLAN AND WILL NOT BE CLAIMED AS AN INCOME TAX DEDUCTION.

Employee's Signature _____ Date _____

**If this is NOT an itemized receipt, please DO NOT submit for reimbursement.**